TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Gulf Coast Orthopedics

Respondent Name
Sompo America Fire & Marine Insurance Co.

MFDR Tracking Number
M4-25-0900-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
December 20, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 26, 2024	20103	$2,875.00	$0.00
July 26, 2024	64722	$1,918.00	$0.00
July 26, 2024	15853	$58.00	$0.00
	Total	$4,851.00	$0.00

Requestor's Position

"20103, 64722 and 15853 qualify for reimbursement... 20103 FOR EACH DIGIT IS SEPARATELY PAYABLE AS NEITHER OF THE MAJOR STRUCTURES REPAIRED REQUIRED ... NCCI EDITS DO NOT BUNDLE ANY OF THESE PROCEDURE TOGETHER IN ANY COMBINATION OF MAJOR AND MINOR CODE AS NONE OF THE OTHER CODES DESCRIBE THE WORK PERFORMED FOR 64722."

Amount in Dispute: $4,851.00

Respondent's Position

"Based upon the EOB dated October 21, 2024, the carrier paid the provider the amount of $2,874.39. This was based upon CPT codes 13160 and 26020. The provider has been paid pursuant to the Medical Fee Guidelines. The provider is not entitled to any additional monies."

Response submitted by: Flahive, Ogden & Latson

Respondent's Supplemental Position

"The bill(s) in question was/were escalated and a review completed. Our bill audit company has determined that additional monies are owed in the amount of $30.23. Interest in the amount of $17.49 has been added. Attached are an updated copy of the Explanation of Benefits and payment summaries for your records."

Supplemental Response submitted by: Gallagher Bassett

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203 sets out fee guidelines for professional medical services.
3. 28 TAC §133.210 sets out medical documentation requirements.

Denial Reasons

The insurance carrier reduced/denied the payment for the disputed services with the following claim adjustment codes:

- 90121 & 59 - Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.
- 90145 & 107 - Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim.
- 292 - This procedure code is only reimbursed when billed with the appropriate initial base code.
- 90204 & B15 - This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.
- 299 - This service is an integral part of the total service performed and does not warrant separate procedure charge.
- 97 - Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 193 - Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

- P12 - Workers' compensation jurisdictional fee schedule adjustment.
- 90147 & 109 - Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
- ZK10 - Resolution Manager Denial
- ADJ – No preauth obtained for service

Issues

1. What rules apply to reimbursement of the services in dispute?
2. Is the requestor entitled to reimbursement for the disputed procedure codes 20103 and 64722-59?
3. Is the requester entitled to reimbursement for procedure code 15853?

Findings

1. The requestor seeks reimbursement for surgery services rendered in an ambulatory surgical center (ASC) on July 26, 2024. DWC finds that Rule 28 TAC §134.203(b)(1) applies to reimbursement of the services in dispute, stating, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

2. The requestor is seeking additional reimbursement for surgery services rendered on July 26, 2024.

   A review of the explanation of benefits (EOB) submitted finds that for the procedure codes in dispute the denial reasons are as follows:

   - 20103, which is described as "wound exploration – trauma", was denied by the insurance carrier with reason code 299, "this procedure is an integral part of the total service performed and does not qualify for separate payment."
   - 64722, described as "Neuroplasty (Exploration, Neurolysis or Nerve Decompression) Procedures on the Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System", was denied by the insurance carrier with reason code 97, "Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated."

   The requestor appended procedure codes 64722 and 15853 with modifier "59" indicating a distinct and separately identifiable service.

   Per Medicare Modifier 59 and X(EPSU) Fact Sheet, "Modifier 59 identifies procedures/services, other than E/M services and radiation treatment management, which are not normally reported together, but are appropriate under the circumstances.

Documentation must support:
A different session,
Different procedure or surgery,
Different site or organ system,
Separate incision/excision,
Separate lesion, or
Separate injury (or area of injury in extensive injuries)…

Do not report modifier 59 or other NCCI-associated modifiers to bypass an edit unless documentation in the medical record supports its use."

On the same medical bill and date of service, the requestor also charged and was allowed payment in the total amount of $2,874.39 for procedure codes:

- 13160, described as "secondary closure of surgical wound or dehiscence, extensive or complicated."
- 26020, described as "drainage of tendon sheath, digit and/or palm, each."

28 TAC §134.203(b)(1) states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

DWC completed NCCI edits and found the following conflicts: (disputed codes are underlined)

- Per Medicare CCI Guidelines, procedure code 13160, which has been allowed payment, has an unbundle relationship with history procedure code 20103. Review documentation to determine if a modifier is appropriate.
- Per Medicare CCI Guidelines, procedure code 64722 has an unbundle relationship with history procedure code 26020, which has been allowed payment. Review documentation to determine if a modifier is appropriate.

A review of the documents submitted finds that no operative report was submitted with the request for this medical fee dispute resolution (MFDR).

28 TAC §133.210, which sets out the requirements for medical documentation, states "(c) In addition to the documentation requirements of subsection (b) of this section, medical bills for the following services shall include the following supporting documentation: … (2) surgical services rendered on the same date for which the total of the fees established in the current Division fee guideline exceeds $500: a copy of the operative report."

DWC finds no documentation to support separate reimbursement of the disputed procedure codes 20103 and 64722-59. Therefore, no additional reimbursement can be recommended for procedure codes 20103 and 64722-59, billed for date of service July 26, 2024.

3. The requestor is seeking reimbursement for procedure code 15853, rendered on July 26, 2024, in an ambulatory surgical center. Procedure code 15853 is described as, "removal of sutures or staples not requiring anesthesia".

   Per Medicare Guidelines, procedure code 15853 only applies to non-facility settings such as offices or homes and does not have physician work relative value units (RVUs) assigned. Therefore, no reimbursement is recommended for procedure code 15853 billed for date of service July 26, 2024.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requestor has not established that reimbursement is due for the disputed services.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		March 12, 2025
Signature	Medical Fee Dispute Resolution Officer	Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.